



Office of Emergency Medical Services

APPLICATION FOR ACCREDITATION

Section I

Approval Number	
____/____/____	____/____/____
Start date	End date

Date application received by OEMS

Please print and complete all requested information.

1. APPLICANT STATUS:

- ☐ **First Time Applicant:** Initial application
- ☐ **Previously Accredited:** Accreditation renewal
- ☐ **Substantially Equivalent Accreditation:** Provide letter of intent & documentation of current
"Allied Health EMS Training Accreditation"

2. APPLICANT CONTACT INFORMATION:

a. Legal Name of Training Institution

Legal Name of Institution

b. Training Institution Location Address (Physical Location of Institution)

Address Number

Street name

City/Town

State

Zip Code

c. Training Institution Mailing Address (if different from Physical Location Address)

Address Number/PO Box

Street name

City/Town

State

Zip Code

d. Voice/Fax Electronic Contact Information

Telephone # () _ _ _ _ - _ _ _ _ _ FAX # () _ _ _ _ - _ _ _ _ _

Institution Web Address

- e. Official representative for the institution, and the EMS program operation/administration, who prepared application responses. This person will serve as the official liaison between the institution, and OEMS.

First Name

Middle Initial

Last Name

Official Title

Telephone # () _ _ _ _ - _ _ _ _ _ FAX # () _ _ _ _ - _ _ _ _ _

e-mail address _____

3. **LEVEL OF EMS TRAINING INSTITUTION PROVIDES:** Please check appropriate box or boxes

Initial EMT Training (Curriculum/Minimum Hrs.)

Refresher Training

Continuing Education

☐ EMT-Basic (DOT 1994 110 Hr. Minimum)

☐ EMT-Basic Refresher

☐ EMT-Basic

☐ EMT-Intermediate (DOT 1985 250 Hr. Minimum)

☐ EMT-Intermediate

☐ EMT-Intermediate

☐ EMT-Paramedic (DOT 1998 1050 Hr. Minimum)

☐ EMT-Paramedic

☐ EMT-Paramedic

4. **TYPE OF INSTITUTION:***(Check appropriate box, and circle appropriate title)*

a) ☐ Four-year College/University

b) ☐ 2 Year Technical or Community College

c) ☐ Hospital/Medical Center

d) ☐ Vocational/Technical School/High School

e) ☐ United States Military (DOD Army, Navy, Air Force, and Coast Guard)

f) ☐ State, county, or local government

g) ☐ Other public or private entities that meet State & local business license requirements

5. **EMS TRAINING INSTITUTION PERSONNEL:**

a) Medical Director:

First Name

Middle Initial

Last Name

Telephone # () _ _ _ _ - _ _ _ _ _ FAX # () _ _ _ _ - _ _ _ _ _

E-mail _____

Massachusetts Medical License Number: _____

b) Director/Coordinator:

First Name

Middle Initial

Last Name

Telephone # () _____ - _____ FAX # () _____ - _____

E-mail _____

b) Clinical Coordinator (where applicable):

First Name

Middle Initial

Last Name

Telephone # () _____ - _____ FAX # () _____ - _____

E-mail address _____

Massachusetts EMT Certification # _____

Nurse License #: _____

c) Field Internship Coordinator (where applicable):

First Name

Middle Initial

Last Name

Telephone # () _____ - _____ FAX # () _____ - _____

E-mail address _____

Massachusetts EMT Certification # _____

Nurse License #: _____

6. **FACILITIES:**

a) Location (actual location of didactic & lab training, if more than one location provide on separate sheet)

Name of facility and/or building(s)

Address Number

Street name

Suite Number

City/Town

State

Zip Code

b) Facility's Student Capacity (didactic & lab training)

☐ 10-20 ☐ 20-30 ☐ 30-40 ☐ 40-50 ☐ greater than 50 Provide # _____

7. ALS CLINICAL INTERNSHIP SITES AND RESOURCE SUMMARY:

List all clinical sites affiliated with training institution. Provide an expiration date for each affiliation agreement and list the number of students that will be allowed in each medical specialty area. If a class has thirty students, clinical sites collectively must support 30 students.

	Hospital Name	Expire. Date	ED	OR	ICU	PSYC	L&D	IV	PEDI	Other
sample	XYZ Hospital	01/01/05	20	10	20	none	15	20	20	
sample	All Care Hospital	07/30/05	10	20	10	30	15	10	10	
1.										
2.										
3.										
4.										
5.										
6.										
7.										
8.										
9.										
10.										
11.										
12.										

8. ALS FIELD INTERNSHIP SITES AND STUDENT RESOURCE SUMMARY:

List all field internship sites affiliated with training institution. Provide an expiration date for each field affiliation agreement. The field internship resources must be able to collectively support the skill requirements for your students. If class has thirty students, field sites collectively must be able to support 30 students.

	Service Name	Initiation Date for Agreement	Expiration Date for Agreement	Min # Students	Max # Students	ALS Survey
Sample	XYZ Ambulance Service	December 31, 2004	December 31, 2005	5	10	Yes
Sample	P-Medic Transport, Inc.	December 31, 2004	December 31, 2005	15	25	Yes
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						

9. BACKGROUND:

- (a) Describe applicant's training experience with operating an EMS training program approved in Massachusetts under 105 CMR 170.000, or in another state or jurisdiction; or experience in operating adult vocational training or higher educational programs. (Attach supporting documentation.)

Please indicate number of training program years of experience: _____

- (b) Does the applicant have a training compliance history in any other state or jurisdictions?

☐ Yes ☐ No (If **yes** attach an explanation, and or supporting documentation.)

- (c) Describe the applicant training institution's financial resources that will be provided for the operation of the EMS training program, for the three-year accreditation period. (Attach supporting documentation, including copies of current financial statement or current budget.)

- (d) Complete and forward to OEMS, with application packet, the Authorization To Request Criminal Offender Record Information (CORI) forms for program personnel (copy of authorization form is attached as appendix A) include at a minimum:

- | | |
|--|-----------------------------------|
| 1. Medical director | 2. EMT program director |
| 2. Clinical coordinator | 4. Field internship coordinator |
| 3. Didactic instructor/coordinator (s) | 6. Adjunct faculty as appropriate |

10. AFFIRMATIONS:

- (a) ☐ Attest to applicant training institution's legal capacity to operate. (Attach supporting documentation, including copies of articles of incorporation and corporate by-laws).

- (b) ☐ The applicant training institution hereby affirms that they comply with, and will continue to comply with, all relevant federal and state laws, including but not limited to, federal and state anti-discrimination statutes, M.G.L. c. 111C; regulations, including but not limited to 105 CMR 170.000 and 105 CMR 700.000, and the Department's Administrative Requirements, the Statewide Treatment Protocols, policies and advisories.

- (c) ☐ The applicant training institution hereby affirms it meets eligibility requirements for accreditation pursuant to 105 CMR 170.946, and that it can and will fulfill the duties and obligations of accredited training institutions pursuant to 105 CMR 170.950, which includes the duty to administer the Massachusetts EMT practical examination requirements, in accordance with Administrative Requirement (A/R) 2-214.

- (d) ☐ The training institution hereby affirms that the most current Massachusetts EMS Statewide Treatment Protocols are taught as part of the training curriculum.

- (e) ☐ The training institution hereby affirms that they comply with all NHTSA/DOT EMS standards, as implemented by the Department.

- (f) ☐ The training institution hereby affirms that if any of the application information changes, the institution will notify OEMS immediate.

NOTE: The individual whose name appears below is the official representative of the EMS training institution, and must have legal authority to sign all of the necessary program documents and to make legally binding contracts.

I _____
(Print Name) (Title) (Signature)

hereby affirms that all information provided to DPH/OEMS in the application packets sections II and I is up-to-date and accurate. _____

(Date)

11. **OEMS ACCREDITATION REVIEW FOR APPROVAL:**

a. 105 CMR 170.948: Finding of Responsibility and Suitability of Applicant for Accreditation

Upon receipt and review of an application for accreditation, the Department shall make a finding concerning the responsibility and suitability of the applicant training institution pursuant to factors contained in 105 CMR 170.948.

- ☐ *The Department hereby makes a finding of responsibility and suitability for the accreditation applicant.*
- ☐ *The applicant is found not to be in compliance with 105 CMR 170.948 standards, and is hereby not approve at this time.*

b. The Training Institution Did Not Receive Department Approval for The Following Reason (s)

- ☐ DOT National Standard curriculum deficiencies
- ☐ Institution does not meet the Massachusetts minimum training hour requirement.
- ☐ Institution does not meet the Massachusetts skill performance requirements.
- ☐ Institution does not have adequate training facilities, resources, and/or training equipment.
- ☐ Institution does not provide adequate clinical, and/or field internship resources.
- Other
- (A written explanation will be sent to applicant with in 10 working days of findings)

c. Provisional Training Institution Accreditation

The Department may issue provisional accreditation to an applicant who does not meet the requirements of 105 CMR 170.946 through 170.953, provided that the applicant has demonstrated to the Department's satisfaction a good faith intention to meet all such requirements and provided that the Department finds the applicant provides adequate EMT training and evidences a potential for full accreditation within a reasonable period, **not to exceed one-year**.

- ☐ The Department issues approval for provisional accreditation.

d. Substantially Equivalent Accreditation

- ☐ The Department issues approval based on Substantially Equivalent Accreditation (OEMS accreditation term shall run concurrent with existing accreditation)

e. Department Accreditation Approval

- ☐ The Department issues accreditation approval in accordance with 105 CMR 170.946(E), and Department administrative requirements.

The Department accredits the training institution for a period of

Effective date: _____ / _____ / _____

To

Expiration date: _____ / _____ / _____

APPLICATION FOR ACCREDITATION

Section II - Training Institution Qualitative Assessment

Institution Name: _____

Application Prepared By: _____
First Name Last Name

Instructions

- Complete in full all information requested.
- If you are unable to answer any area and/or question, provide a written explanation for the omission.
- Provide five copies to OEMS.
- Each section of your explanation shall be included in a Table of Contents and follow the outline below.

A. OVERVIEW

Please attach copies of current policies, procedures, and/or supporting documentation for each the following:

1. Program mission, goals, and objectives;
2. Number of EMS courses conducted annually, indicate levels (initial EMT-Basic, EMT-Intermediate, EMT-Paramedic), and type (refresher, continuing education);
3. Number of students taught per course per year, for past two-years;
4. The Americans with Disabilities Act applicable to EMT training accommodations;
5. Use and secure storage of controlled substances and instruments for administration of controlled substances in EMT training programs, in accordance with requirements of the Department's Division of Food and Drugs, pursuant to 105 CMR 700.000;
6. Clinical and field affiliation agreements; Affiliation agreements shall include the following:
 - a) Name of training program,
 - b) Name of organization providing clinical/field site(s),
 - c) Number of students allowed per site,
 - d) Duration of agreement,
 - e) Details of supervisory responsibilities,
7. Forms used for clinical and field internships, time and skill logs, and describe internship process students will follow;
8. EMT training institution organizational chart that shows the relationship among students, faculty, medical director, program director/coordinator, and other personnel for each EMS training course; and
9. Sample course outline for EMT-Basic, EMT-Intermediate, and EMT-Paramedic level of initial EMT training provided.

B. STUDENTS

Please provide copies of current policies, procedures, and/or supporting documentation for the following:

1. General program requirements for student selection and admission.
2. Program requirements for student:
 - (a) Attendance,

- (b) Absentee makeup,
- (c) Academic counseling; and
- (d) Student evaluations.

C. PERSONNEL RESOURCES

A Massachusetts accredited EMS training institutions shall have adequate and appropriately credentialed staff to ensure all training and educational standards are met.

Faculty

Please provide copies of current supporting documentation for the following:

- (a) Relevant resumes for EMS faculty; describing training background; limited to one-page each; and
- (b) Copy of current license / certification (where applicable), and job descriptions that includes detailed training program responsibilities for:

- 1) Medical director
- 2) EMS Director
- 3) Clinical coordinator
- 4) Field internship coordinator
- 5) Didactic instructor/coordinator
- 6) Instructor aides
- 7) Preceptors

- (c) Preceptor policies, and describe manner by which policies are implemented.

D. EVALUATION

Training course evaluation is the examination of multiple components to determine if the course was cost-efficient, educationally sound, and otherwise beneficial.

1. Program:

Please provide current supporting documentation for the following:

- (a) A three-year accreditation evaluation plan which shall include:
 - 1. Clearly defined goals and objectives.
 - 2. An annual update that will provide written evidence the educational program is meeting its objectives and the changing needs of EMS care.
 - 3. Methods for gathering and analyzing data on the effectiveness of the program's:
 - i Curriculum,
 - ii Training equipment, medical library, and computer resources,
 - iii Faculty; and
 - iv A student's ability to function as entry-level providers upon successful completion of the training course.
- (b) Describe how EMS training program evaluations are used for continuous quality improvement, and to plan the future direction of EMT training.

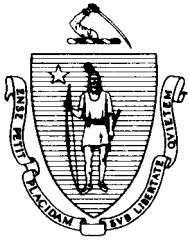
2. Supervision: Describe EMS training institution's policy by which program supervisors conduct staff's evaluation (provide sample evaluation) as it pertains to:
 - (a) Preparation and availability of instructional material,
 - (b) Ability to motivate class and provide a positive learning experience,
 - (c) Audiovisual materials appropriate for class instruction; and
 - (d) Effectiveness of instructional technique.
3. Medical Director
 - (a) Describe manner and criteria by which medical director will review for approval curriculum and course content
 - (b) Describe how medical director will participate in program quality assurance and quality improvement process
4. Clinical Internships (ALS programs)
 - (a) Describe how the training institution interacts with hospital staff to achieve clinical internship goals
 - (b) Describe how clinical coordinator will ensure student achievement of all required clinical competencies
 - (c) Describe how clinical coordinator will participate in the review and evaluation of overall student performance, with emphasis on clinical skill competencies
5. Field Internships (ALS programs)
 - (a) Describe how the training program interacts with ambulance service providers to achieve field internship goals
 - (b) Describe how field internship coordinator will ensure student achievement of all required field skill competencies
 - (c) Describe how field internship coordinator will participate in the review and evaluation of student performance, with emphasis on field skill competencies
 - (d) Describe how field internship coordinator will train, monitor, and maintain consistence of field internship preceptors.
6. Clinical & Field Sites: Describe how clinical and field sites are evaluated for adequacy of skill opportunities for Intermediate and Paramedic students, optional for initial EMT-Basic training course.
7. Practical Skills Examination: Provide documentation of the training institution's plan for conducting the OEMS EMT practical certification examination and related components.
Key Policies are at a minimum:
 - (a) The institutions hiring policy regarding examiners.
 - (b) The institution's formal process for notifying students of their examination eligibility.
 - (c) Describe the institutions administrative process for dealing with re-test and challenge candidates.
 - (d) The training institution's medical director (ALS examinations only) available during practical exam periods.
 - (e) The training institution's examination team will consist of OEMS-approved Examiners to be provided at the training institution's expense (Chief Examiner will be provided by OEMS). The training institution will schedule sufficient numbers of OEMS-approved Examiners to complete a practical examination in a timely manner; average recommended time is 5 continuous hours.
 - (f) Continuous inspection, cleaning, and upgrading of practical examination required equipment.
 - (g) The institution's formal administrative process for managing and scheduling examinations in relation to course completion, when will exams occur, who is responsible for oversight of candidate's certification application completion, and the timely submission of candidates applications to OEMS.

APPENDIX A – Authorization for CORI Request

Instructions

Complete the attached form and forward to OEMS, with application packet, for the following personnel:

- Medical director
- EMT program director
- Clinical coordinator
- Field internship coordinator
- Didactic instructor/coordinator (s)
- Adjunct faculty as appropriate



The Commonwealth of Massachusetts

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Executive Office of Health and Human Services

Department of Public Health

Office of Emergency Medical Services

2 Boylston Street, 3rd floor

Boston, MA 02116

(617) 753-7300

Fax: (617) 753-7320

MITT ROMNEY
GOVERNOR

KERRY HEALEY
LIEUTENANT GOVERNOR

RONALD PRESTON
SECRETARY

Paul J. Cote, Jr.
COMMISSIONER

AUTHORIZATION TO REQUEST CRIMINAL OFFENDER RECORD INFORMATION

APPLICANT INFORMATION:

PRINT LAST NAME FIRST NAME MIDDLE INITIAL

DATE OF BIRTH: ____/____/____ PLACE OF BIRTH _____

SOCIAL SECURITY NUMBER: ____/____/____

MOTHER'S MAIDEN NAME _____

SEX: _____ HEIGHT: ____ FT. ____ IN. WEIGHT: _____ EYE COLOR _____

CURRENT ADDRESS: STREET _____

CITY: _____ STATE: _____ ZIP CODE: _____

FORMER ADDRESS: STREET _____

CITY: _____ STATE: _____ ZIP CODE: _____

PLEASE SIGN AND DATE THE STATEMENT BELOW:

I, _____ hereby give permission to the Massachusetts Department of
Public Health, Office of Emergency Medical Services to request my Criminal Offense Record Information (CORI).

Date: _____